Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4706HOS	A. BUILDING _____ B. WING _____	02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MOUNTAIN SAHARA	5460 WEST SAHARA LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 02/25/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00024560 was substantiated with deficiencies cited. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000		
S 134 SS=D	NAC 449.329 Admission of Patients 2. Ensure that each patient, or the parent, guardian or other person legally responsible for the patient, receives information about the proposed care of the patient. This Regulation is not met as evidenced by: Based upon record review and interview, the facility did not ensure that the person legally responsible for one of three sampled patients was not appropriately informed about the care and condition of the patient (Patient Identifier: 1).	S 134		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE